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ARMY MEDICAL DEPARTMENT ISSUES FROM OPERATION DESERT SHIELD

BY

LIEUTENANT COLONEL GERALD A. PALMER
United States Army

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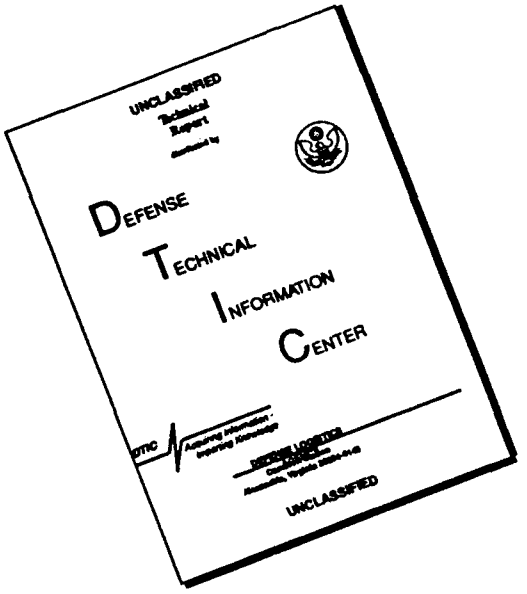
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REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; distribution is unlimited.
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT NUMBER(S)	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION U.S. Army War College Carlisle Barracks 6b. OFFICE SYMBOL (If applicable)	7a. NAME OF MONITORING ORGANIZATION
6c. ADDRESS (City, State, and ZIP Code) Carlisle, Pennsylvania 17013-5050	7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING/SPONSORING ORGANIZATION 8b. OFFICE SYMBOL (If applicable)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c. ADDRESS (City, State, and ZIP Code)	10. SOURCE OF FUNDING NUMBERS PROGRAM ELEMENT NO / PROJECT NO. / TASK NO. / WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
Army Medical Department Issues From Operation Desert Shield

12. PERSONAL AUTHOR(S)
LTC Gerald A. Palmer

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Final MSP	FROM _____ TO _____	91/04/01	29

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

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This paper focuses on issues that presented themselves as the process of responding to the crisis unfolded. They are: Deployability criteria of the Reserve Component personnel; Clarity of readiness status of units being activated; and, Command and control of medical assets in theater. Each issue is very broad in and of itself, but is further narrowed in the discussion to the relationships between law or policy and the realities of the units

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT ☐ DTIC USERS	Unclassified
22a. NAME OF RESPONSIBLE INDIVIDUAL LTC Lorna R. Strzelecki, Project Adviser	22b TELEPHONE (Include Area Code) 717/245-3845 / 22c. OFFICE SYMBOL AWCAA

DD Form 1473, JUN 86 *Previous editions are obsolete.* SECURITY CLASSIFICATION OF THIS PAGE

USAWC MILITARY STUDIES PROGRAM PAPER

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ARMY MEDICAL DEPARTMENT ISSUES FROM OPERATION DESERT SHIELD

AN INDIVIDUAL STUDY PROJECT

by

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ABSTRACT

AUTHOR: Gerald A. Palmer, Lieutenant Colonel, U.S. Army

TITLE: Army Medical Department Issues from Operation Desert Shield

FORMAT: Individual Study Project

DATE: 1 April 1991 PAGES: 29 CLASSIFICATION: UNCLAS

At the outset of Operation Desert Shield, the Army Medical Department (AMEDD) quickly realized that it would be required to play a critical role in the operation. Throughout the crisis, however, significant challenges arose along the path of preparation. The AMEDD is organized with, roughly, seventy-five percent of its forces in the reserve components. Much of the call-up ordered by the President was for medical units and personnel. It is because of this significant weighting in the reserves of the medical assets that many of the issues were identified. It is also true that the use of the unique Presidential Call-up authority surfaced some of these issues.

This paper focuses on issues that presented themselves as the process of responding to the crisis unfolded. They are: Deployability criteria of the Reserve Component personnel; Clarity of readiness status of units being activated; and, Command and control of medical assets in theater. Each issue is very broad in and of itself, but is further narrowed in the discussion to the relationships between law or policy and the realities of the units attempting to execute those policies. The methodology for the collection of issues consisted of interviews with leaders, consultants, and officers within the Office of the Surgeon General, U.S. Army, and at the Headquarters, U.S. Army Health Services Command and the Academy of Health Sciences, U.S. Army. A literature review was conducted of the legal and policy documents relating to the Presidential Call-up authority and the implementation of that Executive Order. The review included existing and developing AMEDD doctrinal literature to draw comparisons to the events as they occurred.



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INTRODUCTION

On August 2, 1990, United States citizens awoke to the news that Iraq had invaded the tiny country of Kuwait and had brutally put down any opposition. Iraq's official statement said that the Kuwaiti government was overthrown by revolutionaries who asked Iraq for help.[1]

As time passed, a myriad of political actions unfolded in the Iraq-Kuwaiti situation. By the seventh of August, President Bush ordered U.S. combat troops to Saudi Arabia to counter the possibility of an Iraqi invasion there and to assist the Saudis in their defense. Three days later, the Arab League, in an historic move, voted to send troops to Saudi Arabia, thereby forming a coalition force against Iraq. Only Libya and the Palestine Liberation Organization (PLO) openly backed the Iraqis. By the fourteenth of August, the Pentagon announced that more than twenty thousand troops were deployed to Saudi Arabia and that consideration was being given to a call-up of reserve forces.[2] On August 22, 1990, the President issued an Executive Order directing a limited call-up of reservists. Secretary of Defense Dick Cheney issued his directive to the services which began the most extensive expansion of the Armed Forces in forty years.[3]

The President's decision to deploy forces to Saudi Arabia activated Operation Desert Shield. The U.S. Central

Command from MacDill Air Force Base, Florida was designated the senior U.S. headquarters, with General H. Norman Schwarzkopf in command.

From these much discussed and little expected actions, the United States and its Department of Defense found itself in many very new situations. Deployments had occurred; command alignments had been ordered; reserves had been activated; but not at this magnitude.

Army Medical Department Perspective

At the outset of Operation Desert Shield, the Army Medical Department (AMEDD) quickly realized that it would play a critical role in the operation. The AMEDD is an integral part of the logistical team providing needed combat service support during a deployment. But, the challenge and importance of health service support increases significantly when the possibility of lethal combat becomes real. Throughout the crisis, however, significant challenges arose along the path of preparation.

Much of the call-up ordered by the President was for medical units and personnel, because the AMEDD is organized with, roughly, seventy-five percent of its forces in the reserve components. With the execution of the Presidential Call-up authority, many reserve-connected issues were identified.

Issues and Methodology

Many issues were identified during Operation Desert Shield, but this discussion focuses on three issues that surfaced as the crisis unfolded. They are: deployability criteria of the Reserve Component personnel; clarity of readiness status of units being activated; and, command and control of medical assets in theater. Each issue is very broad in and of itself, but the focus will be on the relationships between law, policy, or doctrine and the realities of the units attempting to execute those policies.

The methodology for the collection of issues consisted of interviews with leaders, consultants, and officers within the Office of the Surgeon General, U.S. Army, and at the Headquarters, U.S. Army Health Services Command and the Academy of Health Sciences, U.S. Army. A literature review was conducted of the legal and policy documents relating to the Presidential Call-up authority and the implementation of that Executive Order. The review included existing and developing AMEDD doctrinal literature to draw comparisons between stated doctrine and the events as they occurred.

DEFLOYABILITY CRITERIA FOR RESERVE COMPONENT PERSONNEL

Title 10, Section 671, of the United States Code (10 U.S.C. 671) requires that all members of the armed forces complete the basic training requirements for their service prior to assignment to active duty on land outside the United States and its territories and possessions. The law does not define a minimum length for this basic training during peacetime, but states that "....in time of war or national emergency declared by Congress or the President, the period of required basic training (or its equivalent) may not be less than twelve weeks. " [4,5]

When the Presidential Call-up was announced, the Assistant Secretary of Defense, Force Management and Personnel, further directed that individuals who had not completed twelve weeks of training or the equivalent would not be activated.[6]

Within the AMEDD, there are considerable numbers of officers who do not meet the twelve week training requirement, if the requirement is defined in literal terms. Those literal terms are generally understood to mean twelve weeks of military related training conducted under an approved program of instruction at a branch or service school responsible for training and preparation of the officer for branch qualification. This considerable number

of officers are, however, already recognized as fully functioning members of their reserve units and very necessary to those units for mission capability.[7]

A complicating factor in the process of calling up units and personnel from the reserves is the limitation the law places on the President or Secretary of Defense acting in his behalf. The limitation is that when a unit is called, those members of the unit who are not eligible for call-up, or for mission performance, must be released and may not be recalled. Two specific actions result from this limitation. First, the Army, in this case the AMEDD, must be very precise in the manner of selecting units for call-up. A specific unit may be doctrinally required, but the Army must determine exactly what capabilities will be received, before issuing the call-up order, so as not to lose the opportunity to gain those skills. Secondly, the Army must then determine how to insure that the most advantageous process is used for each unit.[8]

Operation Desert Shield revealed several examples of situations in which these policies must be reviewed for possible changes to facilitate a smoother response during crisis action. The basic training definition for AMEDD officers is one such example.

Because the AMEDD has requirements for a wide variety of medical specialties, there are very detailed descriptions of the precommissioning requirements for these specialties. Most of these descriptions provide for clear qualifications in a skill area, such as degree completion or certification in a specialty. Also, the AMEDD frequently uses these criteria for direct commissioning determinations. Nevertheless, the precommissioning professional training constitutes the necessary preparations for officers with professional degrees to be brought into the Army as qualified practitioners. Therefore, the AMEDD does not need twelve weeks to provide sufficient additional training for these officers to be branch qualified. The Surgeon General of the Army requested an exception to the policy guidance from the Secretary of Defense to allow activation of the reserve component AMEDD personnel who do not meet the twelve week training requirement. The thrust of this request was the equivalency determination for precommissioning professional training. The Surgeon General also requested authority to deploy such individuals following completion of minimum deployability training of two weeks. The Surgeon General recommended that a ten week equivalency be granted for the precommissioning training, thereby leaving a two week requirement to complete necessary military subjects for deployability. [9]

By mid-December, 1990, the request of the Surgeon General had received approval at the Army staff and Secretary of the Army levels, but was awaiting approval at the Office of the Secretary of Defense(OSD) level. In the interim, unique procedures were required to insure that deploying units were not decimated by a severe loss of staff.

In the absence of a policy exception, the Army officials followed the existing procedures to meet mission requirements. This necessitated at least three specific actions. First, based on the Secretary of the Army approval and the assumption of OSD approval, the "services basic training" requirement was defined as two weeks, with ten weeks equivalency for precommissioning training. This did not violate Title 10, because there was no declaration of war or national emergency, but it did presume the ability to gain approval for the equivalency definition prior to a declaration by the President or the Congress. If the approval was not granted, the law would stand as written and many health care professionals would be ineligible for service on active duty until completion of the minimum training requirements. In the jargon of the Pentagon staff, this would be a "war-stopper".

Secondly, the Army determined which officers in units being alerted required deployment training. These officers

were assigned to a derivative unit identification code (UIC) of their parent unit. The derived unit was brought to active duty for training, under 10 U.S.C. 672b which provides for up to fifteen days of training per year, to receive the required two weeks of deployment training. Upon completion of the training, the personnel of the derivative unit now met the guidance of the Secretary of Defense and were activated under 10 U.S.C. 673b to join their parent unit.

As the third action required, an amendment to Title 10 was proposed that would grant the Service Secretary the authority to determine the length of basic training, as opposed to the specified length of time currently defined by law. This seems to be a reasonable request, since much of Title 10 grants policy determinations to the Secretary of Defense, who can delegate authority to the Service Secretaries. The proposed amendment was not presented to Congress before adjournment in 1990, and must be prepared for presentation to Congress at the 1991 session.[10]

CLARITY OF READINESS STATUS OF ACTIVATED UNITS

Army Regulation 220-1 (AR 220-1) is the Army's implementation document that satisfies the Joint Chiefs of Staff (JCS) requirements for readiness reporting in JCS Publication 6. The objectives stated in the regulation are to provide a current status of units to the National Command Authorities (NCA), the JCS, HQDA, and all levels of the Army chain of command and to provide specific indicators to HQDA. These indicators are intended to portray conditions and trends, identify factors which degrade unit status, show the difference in current assets and wartime requirements, and assist in the allocation of resources.[11]

The regulation explains in its concept paragraph, that " Unit Status Reports are designed to measure one aspect of unit readiness, the status of resources and training at a given point in time. The report should not be used in isolation to assess overall unit readiness or the broader aspect of Army readiness."[12] The regulation goes on to say that while providing a timely single source document for assessing unit status, the reports do not contain all of the information needed to manage resources. It is this portion of the concept that is often lost in the routine uses of the Unit Status Report data.

During the execution of the activations for the Presidential call-up, the Army Surgeon General's staff monitored the situations of all medical units. One of the initial checks was the unit status level as reported on the Unit Status Report. Units reporting C-3 or better were considered to be sufficiently ready for activation and, if necessary, deployment.

Army officials were well aware of the equipment shortfalls in many reserve component medical units, particularly those hospitalization units which were to be equipped with the Deployable Medical Systems (DEPMEDS).[13] A plan was developed almost immediately to speed up the delivery of necessary materiel to accommodate the deployment.

Likewise, training status levels were accepted as accurate since they reflected the commanders assessment and not a series of specified calculations.

Initially, there was confidence that the personnel status levels would also represent accurate and acceptable resource levels of personnel, but several problems were experienced that raised doubts with either the requirements of AR 220-1 or with the system as executed by the commanders.

The general question is whether or not AR 220-1 and the Unit Status Report provide a sufficient level of detail to know the actual capability of a unit and, thereby, make the determination that the unit is deployment ready or mission capable? The Unit Status Report seems to be used as if it were a sufficient determinant of mission capability. Many say that since the report is the commander's assessment, it should certainly represent a factual, accurate statement of mission capability.

Another view is that AR 220-1 describes a concept and is intended as an indicator, but operators, because of the pressures of time and mission, quickly give the report a broader, stronger meaning. The commander submitting the report has applied the guidance of the regulation and has reported a general indicator of readiness. The examples that follow should point out how compliance with a reporting requirement can camouflage a unit's need for significant actions prior to being mission capable.

As hospital units were alerted for deployment, several were found to have substitute surgical specialties filling their physician slots. (Certain specialties may substitute for others because they possess similar skills. However, the substituted officers must be capable of performing the required tasks.) At the mobilization station, the units were identified as not being mission capable. This example

of a proper peacetime assessment by the commander is viewed much differently in the assessment of potential combat readiness. The true readiness of the unit likely falls between the comparative poles and, if viewed at an active combat triage site, all surgical capabilities are critical to provide mission support. While substitution of certain surgical specialties for a general surgeon is correct under certain conditions, it may be suspect when an opportunity exists to obtain the required specialty.

A second difficulty with the reported readiness levels was found in medical units requiring the 91C, Practical Nurse Specialist (91C is a designator code for a military occupation specialty, or MOS). Many units were critically short of the 91C specialty, but had an excess of other enlisted medical specialties, usually the 91A Medical Specialist. Therefore, the units were reporting an acceptable level in both available strength and MOS qualified strength. Because the shortages lumped themselves into one specialty, the level of detail was not sufficient when only the Unit Status Report readiness levels were used.

This issue in Operation Desert Shield may be less an issue for change of AR 220-1, and more an issue for adjustment of the flexibility of the Presidential call-up authority. The regulation provides sufficient detail for planning, but changes may be required in other areas to

allow for actions that must be taken at the mobilization station. Under the Presidential call-up authority, only the Selected Reserve may be called. The Individual Mobilization Augmentee (IMA) program is an excellent vehicle to identify backfill personnel for known mobilization requirements, because it falls under the Selected Reserve and would be available under conditions such as those in Operation Desert Shield. Authority to activate the Individual Ready Reserve (IRR), which would also provide an individual pool of specialties, currently comes with the declaration of partial mobilization. Another alternative to better allow for the personnel cross-leveling required is to propose changes in the law (Title 10) to allow actions under Presidential authority to activate the IRR.

COMMAND AND CONTROL OF MEDICAL FORCES

No topic in the Army Medical Department generates more emotional response than command and control of medical forces. Wrapped within that subject are the issues of Medical Department control of medical functions, such as medical evacuation and medical logistics; tactical commanders use of medical forces; physician versus non-physician command billets; and, application of health service support doctrine to best achieve the medical mission.

Two issues within this category surfaced during Operation Desert Shield. First is the long standing issue of command selection for medical units. The second is the determination of the appropriate and necessary level of command headquarters to command and control units at various levels of the theater.

Command Selection for Medical Units

Throughout its history, the Army has maintained a policy of Medical Corps (physician) commanders for medical units having a patient treatment mission. Other AMEDD officers have been placed in command of organizations without a direct medical treatment mission, such as medical supply, evacuation, dental, and laboratory units. For more than two decades, the physician policy has been modified to

place Medical Service Corps officers (non-physician administrators) in command of these units during peacetime, but to replace them with a physician when the unit is actively receiving patients (presumably, in wartime). This modification has been made to retain the overall policy of physician command, but to accommodate both a shortage of physicians and the necessity to keep physicians in contact with patients. In Operation Desert Shield, large numbers of medical units were deployed to Saudi Arabia and were preparing for possible combat casualties. Execution of the command policy was not uniform and the questions that have been present for many years must be raised again.

No less than six battalion-equivalent units deployed to the operational area with Medical Service Corps commanders, who had trained and organized the units to respond to their leadership. All of these officers were selected for command by a Department of the Army selection board and were slated for a two year command. Shortly after arrival in the area, five of these officers were replaced in command by physicians in accordance with the policy in AR 600-20. These physicians had been assigned to the units through the Professional Officer Filler System (PROFIS) and were essentially unfamiliar with the operational policies, procedures, or personnel issues within the unit. In the

remaining unit, the senior commander elected not to replace the commander.

There are many emotion-based assessments that are sometimes made concerning the leadership abilities of the officers who are called upon to assume command under these conditions or the ensuing morale of the units in which such changes occur. Those assessments are speculative and argumentative and serve to add little to the discussion. The reality is that the officers appointed perform to the best of their abilities and that the unit personnel work to the best of their abilities to support the appointed commander. The policy of command replacement and command selection is, however, seriously flawed.

The questions, then, are several. Does a policy of physician commanders for active treatment facilities remain necessary? If so, then shouldn't the physician command the unit full time? Does the current policy affect morale in the units involved? Does the current policy deal fairly with the commanders involved? Is the current policy the best policy to produce mission ready units when required? Are non-physician officers, given ancillary training and extensive experience, able to incorporate the medical-specific advice of a staff physician when necessary for the welfare of the patient? And, can a non-physician officer with specific preparation for command better execute

the critical leadership actions of command to the greater benefit of the unit and the overall mission?

The selection of commanders is an extremely important decision and not all officers are capable of command. The question of physician or non-physician is far less important than the question of fundamental knowledge of operational concepts of the Army in the field, knowledge of health service support doctrine and capabilities, and the mettle and training to be a commander. The officers who meet those criteria should be the commanders of medical units preparing for and executing combat missions. An appropriate policy change would result in all qualified AMEDD officers competing for selection to command medical units and remaining in command until the normal completion of the assignment.

Such a policy should include all branches of the AMEDD and would be similar to an existing policy in the Navy. The policy would select only the best qualified commanders and would not be involved in branch quotas or representation. It would seek to place outstanding commanders in units and remove the necessity of replacing a proven commander during possibly the most crucial period of a unit's history.

The policy change described presumes a rational approach to command of medical units. It describes a system

in which the qualification to command and an understanding of the medical mission are the principal attributes, without specific regard to a medical degree.

There is, however, an element of the issue of command in medical units that does not fit this rational model. It relates to the idea that in medicine, the physician is totally responsible for the treatment and healing of the patient and, thus, must be in charge of all aspects of that treatment. This thought process has led to the belief that a physician should not be subordinate to a non-physician in a unit having a patient treatment mission.[14]

The Army is left with a paradox of supporting a policy of physician command, but not providing sufficient preparation for command. The requirements for physicians to fill clinical treatment positions preclude the assignment of physicians to command during other than deployment situations. Conversely, the Army provides extensive training and preparation for command to members of the Medical Service Corps, but retains the policy of replacement by a physician upon deployment and assumption of the patient treatment mission. These situations are directly related to the belief that a physician must make the command decisions, since those decisions may relate to a medical decision within the unit.

Non-physicians, and even some physicians, have great difficulty accepting the premise that a physician is required for the decisions of command. Many view the office of the commander and the accompanying staff as executing the functions of command and control; not direct medical treatment. As in all military organizations, knowledge of the technical mission is necessary, but the true question is what level of technical knowledge is required by the commander of a medical treatment unit?

This issue from Operation Desert Shield mandates a close review of the long standing policy of physician command of medical units. The policy of changing a unit commander at a critical time in mission execution does not serve the best interests of the unit. Similarly, even if it is determined that a physician is required to be in the command position, the commander must be fully prepared to execute those duties. Mission accomplishment must be the focus, with a minimum of distractions.

Command and Control Headquarters

A second issue regarding command and control has also surfaced from Desert Shield. The issue, which clearly is a decision properly considered by the warfighting commander but provides an excellent platform for discussion and

analysis, is that of the appropriate and necessary level of command and control for the medical units in the theater.

Early in the Desert Shield deployment, the Army force consisted of one Corps with an Army headquarters for overall command. During this phase of the operation, the Army commander had a Surgeon for staff advice on health services, the Corps commander had a staff Surgeon, and within the Corps Support Command (COSCOM) there was a Medical Brigade headquarters to command and control all deployed medical units.

As the situation developed and the force structure matured, additional doctrinal interpretations were necessary to accommodate the demands of the battlefield. Medical doctrine, and probably all military doctrine, for Echelons above Corps (EAC) is relatively untested. Many are well taught in the concepts of the doctrine, but it has been rarely executed to insure its validity. Desert Shield quickly became one of those rare opportunities to implement the doctrine and evaluate its effectiveness.

When the decision to enhance the forces in theater was made, the medical planners recognized that support for more than one Corps and for echelons above Corps would be necessary in the theater.[15]

The doctrinal support for a situation such as this is for a Medical Brigade to be assigned to each Corps and for a Medical Command (MEDCOM) to control the medical forces at echelons above Corps. The MEDCOM is a large headquarters, designed to operate at the Theater Army level. It can command and control varying numbers and types of units, depending on the assigned mission and composition of forces supported. Normally, the MEDCOM commander also serves as the Theater Army Surgeon. The MEDCOM commander is authorized as a Major General. [16]

Although the requirement exists, no MEDCOM has been approved in the overall Army force structure for the Southwest Asia scenario. There is, however, a Medical Brigade in the structure in place of the unresourced MEDCOM. Additionally, a Medical Brigade to support the second deploying Corps was available through the Capstone program.

The Army commander decided to request that the Medical Brigade for the second deploying Corps not be activated, requesting, instead, that an active duty Medical Group perform the Corps medical command and control function. An additional request was for staffing of a provisional Medical Group, under the command of the Theater Surgeon, to provide the echelons above corps medical control. Later, following recommendations from the Army staff, the Theater Army did request the deployment of a Medical Brigade headquarters to

support the second deploying Corps elements, but continued individual deployments to staff the provisional Medical Group. Because of the earlier request not to activate and subsequent message exchanges, the reserve Medical Brigade with a capstone alignment to the deploying Corps had been released from alert, and could not be recalled under the current authority. Instead, the medical brigade with the EAC mission was activated and deployed in support of the Corps. Subsequent discussions resulted in the eventual titling of the provisional organization as a MEDCOM, but without requesting deployment of a unit with a corresponding staff. As a result, the theater was organized for medical command and control with a provisional Medical Command at echelons above corps, commanded by a Colonel; a doctrinal Medical Brigade at one Corps (albeit not the capstone unit), commanded by a Brigadier General; and a Medical Brigade at the other Corps, commanded by a Colonel. The approach was workable, but represents a significant departure from doctrine and it certainly failed to take advantage of the opportunity to verify doctrinal recommendations. [17,18]

Army Medical Department doctrine supports the establishment of a MEDCOM under these circumstances, but not in name alone. A MEDCOM is required because of the growth of the projected medical structure. An Executive Summary, prepared for the Army staff, supports this idea. "In

addition to performing doctrinal medical support functions, the Army has numerous tri-service responsibilities: direct support to the hospital ships for aeromedical evacuation, theater single-item manager for Class VIII (medical supply and maintenance) and theater veterinary support. ...Effective orchestration of the Army's medical system to execute these theater responsibilities can only be accomplished by an in-theater Medical Command." [19]

As stated earlier, the determination of the appropriate and necessary levels of command and control is solely the purview of the on-site commander. Examination of the issue, however, can provide insights to why certain choices were made and improve decisionmaking abilities in the future.

CONCLUSIONS

Operation Desert Shield provided many complicated issues that will serve to improve the Army in the future. The issues discussed here were gathered and developed prior to actions resulting after the January 15, 1991, deadline for the departure of Iraqi forces from Kuwait. The future may provide many different issues of equal or greater importance, but during the establishment phase for the medical forces, the issues presented here were, and are, important.

The Army must pursue the amendment of Title 10, U.S.C. to allow the Secretary of Defense to determine the minimum basic training requirements for certain specialties. Such an amendment will allow important policy determinations to be made prior to call-up or mobilization of units or personnel.

The Army should develop an expanded use of the IMA program to provide backfill capability for specialties required in mobilizing units. This expanded capability would be available under the Presidential Call-up authority and would offset many of the shortfalls experienced during Operation Desert Shield. This additional capability would benefit the reserve units activated under such authorities, because it would allow the cross-leveling of specialties

without the necessity of calling additional units or splitting personnel from their assigned organization.

Should the expansion of the IMA not fulfill all of the requirements for personnel cross-leveling, then additional legislation should be proposed to allow activation of the Individual Ready Reserve (IRR) during the use of the Presidential authority to call up to two hundred thousand reservists to temporary active duty.

The Army should allow all Army Medical Department branches to compete for command of medical units and select the most qualified to be commanders. The selected officer should then remain in command throughout the normal command tour and not be replaced during preparation for combat.

Non-medical commanders should receive more training in medical doctrine to insure greater capability in requesting appropriate medical units. Established doctrine for determining the appropriate command and control headquarters for medical units was not followed during Operation Desert Shield. Because of the expansion of the medical force in the theater, use of that doctrine to request establishment of a Medical Command might have provided a greater flexibility in the management of the echelons above corps forces. At a minimum, the available capabilities of the current force structure were not put to full use and,

consequently, an opportunity to evaluate the appropriateness of established doctrine was missed. Expansion of the doctrinal exposure at both the Command and Staff College level and the Senior Service College level is necessary.

The execution of Operation Desert Shield was an extremely complex and challenging operation. Support by the Army in the field and the agencies, commands, and Headquarters, Department of the Army in the United States and Europe was superior. That issues were identified is in no way an indication of shortfall or failure. To the contrary, the identification of issues is the first step toward an even better execution of mission on future operations.

ENDNOTES

1. Michael R. Gordon, "Iraqi Army Invades Capital of Kuwait in Force Exerting," New York Times, 2 August 1990, p. 1.

2. "Days of Crisis in the Persian Gulf," New York Times, 2 September 1990, p. 12.

3. Dick Cheney, Memorandum, Subject: Call of Selected Reserve Units and Personnel to Active Duty, 23 August 1990, p. 1.

4. Ken Leisher, LTC, Statements on Initial Entry Training Requirements submitted to the JULLS Database (JULLS Number 11558-34500),15 November 1990.

5. U.S. Laws, Statutes, etc., United States Code, 1988, Title 10, Section 671,p. 178, (hereafter referred to as "U.S.C.").

6. Leisher, p. 1.

7. Leisher, p. 1.

8. Interview with Merle J. Snyder, COL, Office of the Surgeon General, U.S. Army, Washington, 11 December 90.

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